2015-2016 Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * _____ Month _____ Day _____ Year	Age*	Sex: (Circle)* Male Female
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Medicare Number:	Is Medicare Primary? Yes No	Is Subscriber Retired? Yes No

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ Month _____ Day _____ Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

I give permission for my insurance company to be billed. I give Acton Nursing Service consent for the administration of the Influenza Vaccine to myself or my child and have answered the screening question to the best of my ability.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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***Place Photo Copy of All Insurance Cards Here:**

Provider Name: **Acton Public Health Nursing** Provider PIN#: **12045**

Provider Address: **472 Main Street, Acton MA 01720**

2015-2016 Insurance Information Form

For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:

- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:

- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

For Clinic/Office Use Only:

Signature of Vaccine Administrator: _____

Date of Service	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied (Circle)	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS Given
	IIV3				0.25 0.5	No	Yes No	IM	R Arm L Arm R Leg L Leg		
	IIV3 High Dose	Sanofi Pasteur			0.5	No	Yes	IM	R Arm L Arm		
	IIV4				0.25 0.5	Yes No	Yes No	IM	R Arm L Arm R Leg L Leg		

IIV3 = Inactivated influenza vaccine, trivalent
IIV3 High Dose = Inactivated influenza vaccine, trivalent, high dose
IIV4 = Inactivated influenza vaccine, quadrivalent

For patients to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	____	____	____
2. Does the person being vaccinated have an allergy to eggs or to a Component of the vaccine?	____	____	____
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	____	____	____
4. Has the person to be vaccinated ever had Guillain Barre syndrome?	____	____	____

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